COMMUNITIES THAT CARE
Community Behavioral Healthcare Association

Frank Anselmo, MPA
Chief Executive Officer
3085 Stevenson Drive, Suite 203
Springfield, Illinois 62703
Phone: 217/585-1600
Fax: 217/585-1601
www.cbha.net

Illinois Health Reform Implementation Council
Medicaid Reform

Tuesday, November 16th
Michael J. Howlett Building Auditorium
501 S. 2nd Street, Springfield, Illinois 62756

CBHA would like to thank the Council for the opportunity to provide some brief comments on the issues the Council is soliciting feedback on through public hearings related to Medicaid reform. CBHA's comments follow the format of the specific issues the Council identified in the posting for this hearing.

The Council's first question.

1. ***After January 1, 2014, the Affordable Care Act (ACA) will make about 700,000 more Illinoisans eligible for Medicaid by covering all people with incomes less than 133% of the Federal Poverty Level (now about $14,000 for an individual or $30,000 for a family of four, with 100% federal funding for the first four years.***

   a) ***What are the implications of this significant expansion for the Medicaid Program?***
   b) **Within the bounds of the State's fiscal condition, what changes would improve the Medicaid Program?**

CBHA's comments:

Build a bridge to Community Behavioral Health Care - Access to behavioral health care, treatment and prevention services is a critical component in improving the health care of individuals with chronic and complex conditions, a great return on investment for the state as it builds healthy communities, and will contribute to long-term and immediate cost avoidance for other state and local systems of health care and safety.

Depression, alcohol and drug use are prevalent among individuals with chronic or complex conditions. For example, McKesson's data for individuals enrolled in DHFS' disease management program identified that *40 percent* have a behavioral health diagnosis.

The complexity of the individual's conditions coupled with designated professional shortage or underserved areas in Illinois suggests it would be prudent for a state-wide strategy to determine the best ways to utilize:

1. The BHC expertise of community behavioral health care providers:
   i. In order to serve clients within integrated care models, safety net CBHC providers should be designated essential BHC providers in reform efforts.
2. The lessons learned from CBHC providers should be "mined":
   i. Existing and developing partnerships with primary care providers.
   ii. Integrated Care Learning Community.

3. The Federal exclusion of safety net CBHC providers from ARRA federal incentives and Illinois' challenging fiscal decisions have resulted in the dismantling of CBHC infrastructure in communities across the state for non-Medicaid consumers:
   i. While the state appropriators debate financing for CBHC for the remainder of this year and the next, we want to note CBHC has taken significant reductions in GRF over the past 18 months.

      The very population the expansion is meant to serve has recently seen significant reductions in state-supported CBHC by the circumstances outlined above. Stopping or reversing these cuts would be a desired objective.

   ii. May we suggest to Council members to address the CBHC crisis consideration to further identify then accelerate actions to leverage opportunities for marshalling resources to CBHC and reducing CBHC redundancies across Departments and within divisions in Departments by including CBHC in the implementation under the:
      1. Health Information Exchange/HIT:
         i. We would like to acknowledge the efforts made to date in this area. BHC was included in the state's plan to the federal government and we have been "at the table" for planning discussions for some time.
      2. Health Insurance Exchange.
      3. PA -96-1141 eliminate "siloed" redundancies.

The Council's second question.

2. ***These low-income individuals and families will likely move, from one year to the next, between public coverage through Medicaid and private health insurance supported with tax subsidies through the Health Insurance Exchange.***

   a) How should we ensure continuity of health care -- in benefit coverage and in provider networks?

   CBHA's comments:
   Build a bridge to Community Behavioral Health Care - A simple answer is to ensure continuity of care agreements exist, consumers have choice, that behavioral health care screenings are required, that treatment plans include BHC as necessary, and last but not least that the BHC functions and processes are compensated through prompt and fair payment methodologies.

   The Council's question has layers of complexity as does the above answer as continuity of care should address the consumer movement identified in the question along with:
   1. Emancipated youths need for continuity of care
   2. Separate Medicaid rules across departments and divisions within departments
   3. Medical Model determinations, will they be inclusive of recovery-based BHC?
   4. Inadequate legacy rates for CBHC
   5. EPSDT requirements
   6. Professional Shortage Areas
   7. Underserved Areas

The Council's third question.

3. **The ACA focuses on care management as a central theme of healthcare reform, with the goal of bringing together primary care physicians, specialists, hospitals, long-term care and social service providers to organize care around the needs of the patient to achieve improvements in health.**

   a) **How should the State incorporate the integration of medical services into the Medicaid?**

   CBHA's comments:
   Build a bridge to Community Behavioral Health Care - The state needs to address the CBHC crisis in the current and next round of budget decisions.

   The Council could make sure steps are taken that:
   1. Include in the service package for "Medical Services" CBHC recovery and prevention care treatment and services.
   2. Recognize existing CBHC care management relationships are critical for individuals who comprise special populations, or have acute or chronic BHC needs.
   3. Ensure the rate structure has incentives for improving the health of the consumer and that the metrics for same are inclusive of BHC.
   4. "Mine" lessons learned from models being used in Illinois and from other states to integrate care currently including bi-directional co-location of personnel:
      - BHC specialist in primary care setting.
      - Primary care personnel in BHC settings.

The Council's fourth question.

4. **The ACA emphasizes home and community-based services to reduce the reliance on institutionalization for seniors and persons with special needs and offers new state-plan options for states to cover these services.**

   a) **What changes should be made in Illinois' long term care services system (both institutional and community-based) to improve the quality of care and achieve the most cost-effective delivery of appropriate care to achieve the best outcomes for these complex cases?**

   CBHA's comments:
   Build a bridge to Community Behavioral Health Care.
   1. Prevent unnecessary institutional care:
      a. Preventive BHC care and services.
      b. Expand screenings that include BHC.
   2. Ensure choice for consumers.
   3. Develop adequate alternatives to institutional care.
   4. Develop targeted care, treatment and services inclusive of BHC to high risk and recidivistic populations.
   5. Ensure efficient accountability and service delivery by eliminating redundant and duplicative state requirements and processes.